

MDR Tracking Number: M5-04-1135-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-18-03.

The IRO reviewed therapeutic procedure, joint mobilization, vasopneumatic device, office visits, chiropractic manipulations, neuromuscular re-education, physical therapy re-evaluation, CMT extraspinal, therapeutic activities, myofascial release, ultrasound, electrical stimulation, unlisted procedure, and manual therapy from 12-18-02 through 9-11-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-15-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. The requestor failed to submit relevant information to support components of the fee dispute per Rule 133.307(g)(3) (A-F). Therefore, no review can be conducted and no reimbursement recommended.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 12-18-02 through 9-11-03 in this dispute.

This Order is hereby issued this 20th day of May 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

April 13, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-1135-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 45 year-old male who sustained a work related injury on ___. The patient reported that while at work he slipped and fell injuring his back and left shoulder. The diagnoses for this patient have included lumbar IVD disorder without myelopathy, rotator cuff sprain/strain, shoulder sprain/strain, and lumbar sprain/strain. On 11/20/02 the patient underwent an MRI of the lumbar spine that showed multilevel disc bulges at L2-L3, L4-L5 and L5-S1. The patient also underwent an MRI of the left shoulder on 11/20/02 that indicated tendinosis of the supraspinatus tendons. A repeat MRI of the left shoulder on 1/9/03 showed a partial tear of the subscapularis tendon, and tendinosis of the supraspinatus tendon. A bilateral lower extremity EMG performed on 4/9/03 was reported to be normal. On 6/6/03 the patient underwent left shoulder arthroscopic surgery. The patient underwent a lumbar epidural steroid injection and epidurogram at L5-S1 on 12/19/03. A myelogram dated 1/7/04 indicated an anterior extradural defect at L2-L3, T12-L1 and L5-S1, degenerative lumbar spondylosis at T12-L1, L2-L3 and L5-S1, and degenerative facet joint hypertrophy at L5-S1. A CT scan following the myelogram showed mild traction disc bulge at T12-L1 with disc and spur material mildly effacing the thecal sac, right paracentral disc protrusion at L2-L3, disc bulge at L5-S1, mild degenerative lumbar spondylosis at T12-L1, L2-L3, and L5-S1.

Further treatment for this patient's condition has included physical therapy, chiropractic care and manipulations, injections of the left shoulder and back and oral medications.

Requested Services

Therapeutic procedure, joint mobilization, vasopneumatic device, office visits, chiropractic manipulations, neuromuscular reeducations, physical therapy reevaluation, CMT extraspinal, therapeutic activities, myofascial release, ultrasound therapy, electrical stimulation, unlisted procedure, and manual therapy techniques from 12/18/02 through 9/11/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 45 year-old male who sustained a work related injury to his back and left shoulder on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included lumbar IVD disorder without myelopathy, rotator cuff sprain/strain, shoulder sprain/strain, and lumbar sprain/strain. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, chiropractic care and manipulations, injections of the left shoulder and back, and oral medications. The ___ chiropractor reviewer indicated that all treatments rendered to this patient were parts of various smaller treatment plans for shoulder therapy prior to and post surgical intervention. The ___ chiropractor reviewer also indicated that the dates of service and modalities provided were appropriate parts of treatment plans. The ___ chiropractor reviewer explained that the patient's response to treatment was not a rapid response and that although the patient was at a 18% whole person impairment rating, he was not deemed to be at maximum medical improvement until 10/24/03. Therefore, the ___ chiropractor consultant concluded that the therapeutic procedure, joint mobilization, vasopneumatic device, office visits, chiropractic manipulations, neuromuscular reeducations, physical therapy reevaluation, CMT extraspinal, therapeutic activities, myofascial release, ultrasound therapy, electrical stimulation, unlisted procedure, and manual therapy techniques from 12/18/02 through 9/11/03 were medically necessary to treat this patient's condition.

Sincerely,